OMB Approved 2900-0572
Respondent Burden: 10 minutes

Department of Veterans Affairs

APPLICATION FOR SPINA BIFIDA BENEFITS

PRIVACY ACT INFORMATION: The social security number and other information on this form is requested under 38 U.S.C. chapter 18, which provides benefits to Vietnam veterans' children with spina bifida. Any information on this form may be disclosed outside VA only if authorized under 38 U.S.C. 5701 and the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. Routine disclosures may be made for the following purposes: Debt collection, civil or criminal law enforcement, communications with members of Congress or other representatives, benefits delivery, administration of programs, and personnel administration. Disclosure of the social security numbers for the child and the Vietnam veteran parent is mandatory. Disclosure of other requested information is voluntary; however, failure to furnish that information would impose administrative difficulties which may result in a delay in processing your application for spina bifida benefits.
RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.

1. NAME OF CLAIMANT - CHILD *(First, middle, last)*	2. SOCIAL SECURITY NUMBER OF CLAIMANT - CHILD *(If available)*
3. CLAIMANT - CHILD'S DATE OF BIRTH *(Mo., day, yr.)*	4. CLAIMANT - CHILD'S PLACE OF BIRTH *(City and State)*
5. ADDRESS OF CLAIMANT - CHILD *(Include number and street or rural route, city or P.O., State and ZIP Code)*	6. TELEPHONE NUMBER OF CLAIMANT - CHILD *(include Area Code)* ( )

7. NAME(S) OF NATURAL PARENT(S) *(Please provide information for both)*

A. FATHER *(First, middle , last)*	B. MOTHER *(First, middle , last)*

8. ADDRESS, TELEPHONE NUMBER AND VETERAN STATUS OF NATURAL PARENT(S)

A. FATHER *(Include number and street or rural route, city or P.O.,State and ZIP Code)*	C. MOTHER *(Include number and street or rural route,city or P.O.,State and ZIP Code)*
B. VIETNAM SERVICE? *(If "Yes," provide dates below)* ☐ YES ☐ NO	D. VIETNAM SERVICE? *(If "Yes," provide dates below)* ☐ YES ☐ NO

9. SOCIAL SECURITY NUMBER(S) OF NATURAL PARENT(S)

A. FATHER	B. MOTHER

10. VA CLAIM NUMBER(S) OF NATURAL PARENT(S) *(If veteran previously applied to VA for any benefit)*

A. FATHER	B. MOTHER

11. IF CHILD IS UNDER AGE 18 WHO HAS CUSTODY, IF OTHER THAN NATURAL PARENT? *(Complete Items 11A,11B &11C)*

A. NAME OF CUSTODIAN/GUARDIAN OF CLAIMANT-CHILD	B. RELATIONSHIP TO CHILD ☐ ADOPTIVE PARENT ☐ GUARDIAN ☐ OTHER *(Specify)* _____	C. ADDRESS OF CUSTODIAN/GUARDIAN OF CLAIMANT-CHILD

12A. IF CLAIMANT - CHILD IS AGE 18 OR OLDER HAS THE CLAIMANT- CHILD BEEN DECLARED INCOMPETENT?
☐ YES ☐ NO *(If "Yes," complete Items 12B and 12C)*

12B. NAME AND ADDRESS OF THE COURT WHICH MADE THE FINDING OF INCOMPETENCY?	12C. NAME AND ADDRESS OF GUARDIAN

13. NAME AND ADDRESS OF PRIMARY HEALTH CARE PROVIDER FOR THE CLAIMANT - CHILD

14A. HAS THE CHILD BEEN DIAGNOSED WITH SPINA BIFIDA?	14B. DATE OF DIAGNOSIS *(Mo.,day,yr.)*

14C. IF THE CLAIMANT - CHILD HAS BEEN TREATED/HOSPITALIZED FOR SPINA BIFIDA RELATED DISABILITIES WITHIN THE LAST YEAR, PLEASE PROVIDE THE NAME AND ADDRESS OF EACH HOSPITAL OR OTHER INSTITUTION WHERE THE TREATMENT WAS PROVIDED *(Use reverse or attach a separate sheet if more space is needed)*

I/We, the undersigned, hereby authorize the hospital or physician shown in Items 13 and 14C to disclose and release to the Department of Veterans Affairs any information that may have been obtained in connection with the physical examination or treatment of the child.

15A. SIGNATURE(S) OF PARENT/GUARDIAN/ADULT CHILD	15B. DATE SIGNED
16A. SIGNATURE OF WITNESS *(Required)*	16B. DATE SIGNED

I/We, the undersigned, declare under penalty of perjury that the information provided is true and correct and that the child named in Item 1 above is the natural child of the person(s) named above in Item 7.

17A. SIGNATURE OF CHILD (IF AN ADULT) OR PARENT OR GUARDIAN	17B. DATE SIGNED
18A. SIGNATURE OF VIETNAM VETERAN PARENT (IF AVAILABLE OR DIFFERENT)	18B. DATE SIGNED

SUPERSEDES VA FORM 21-0304, JUL 1997, WHICH WILL NOT BE USED.